Bryan PHYSICIAN NETWORK

PATIENT INFORMATION

Legal Name:			Sex: ❑ M ❑ F
Preferred Name:			Gender: ❑ M ❑ F
Social Security #:	Marital Status: M S D W		Date of Birth:
Address:		City:	State: Zip:
Cell Phone:	Home Phone:	Work Phone:	Preferred Phone: C H W
Primary Care Physician:		Referring Physician/Provider:	
Emergency Contact Name:		Emergency Contact Phone Number:	
Secondary Contact Name:		Secondary Contact Phone Number:	
Preferred Pharmacy:		Pharmacy Phone Number:	
Email Address (to access your health information online):			

PATIENT EMPLOYMENT

❑ Employed ❑ Retired ❑ Disabled ❑ Student ❑ Other

Employer:		Employer Address:	
City:	State:	Zip:	Phone Number:

GUARANTOR/PERSON RESPONSIBLE FOR PAYMENT

(If patient under 19 years of age or incapacitated list person responsible for payment of medical services)

Name:		Relationship to Patient:	
Social Security Number:		Date of Birth:	
Address:		Primary Phone Number:	
City:	State:	Zip:	
Employer:		Employer Address:	

INSURANCE INFORMATION

❑ Medicare ❑ Medicaid ❑ Group Health Plan ❑ VA ❑ Other

Primary Insurance Name:			
Policy Holder Name:	Social Security Number:		Date of Birth:
Address:		Relationship to Patient:	
City:	State:	Zip:	
Employer Name:			
Secondary Insurance Name:			
Policy Holder Name:	Social Security Number:		Date of Birth:
Address:		Relationship to Patient:	
City:	State:	Zip:	
Employer Name:			

ADDITIONAL INFORMATION

Race (please select one)	**Ethnicity (please select one)**	**Language (please select one)**
❑ American Indian or Alaska Native	❑ Hispanic or Latino	❑ English
❑ Asian	❑ Not Hispanic or Latino	❑ Other _____
❑ Black or African American	❑ Decline	
❑ Hispanic		
❑ Native Hawaiian or Pacific Islander		
❑ White		
❑ Other		
❑ Decline		

Complete Information on Back Side of Page

MEDICARE BENEFICIARY AUTHORIZATION

As a Medicare beneficiary/patient, I request that payment of authorized Medicare benefits be made to the Bryan Physician Network. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits payable for related services.

Beneficiary Signature: _____ Date: _____

AUTHORIZATION TO TREAT AND FINANCIAL RESPONSIBILITY

I consent to medical treatment of the named patient.

I authorize the release of any medical information necessary to process insurance claims. I assign those benefits to which I am entitled, for services provided by the Bryan Physician Network. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as the original.

I agree to be financially responsible and make payments to the Bryan Physician Network for all services provided.

I have read and understand this information.

Patient Signature: _____ Date: _____
(Authorized Representative if under the age of 19 or incapacitated)

Witness Signature: _____ Date: _____